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3 October 2009

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Talking shop

LPCs on the communications breakdown with PCTs Pages 5 and 14

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Approximately 1.5-2 g/10 cm^2 EMLA applied for a minimum of 2 hours, maximum 5 hours. ***Male genital skin*** (apply a thick layer of cream under an occlusive dressing). Prior to injection of local anaesthetic. Approximately 1 g/10 cm^2 EMLA applied for 15 minutes. ***Genital mucosa*** (adults) (no occlusive dressing required). For surgical treatment of localised lesions. Up to 10 g EMLA for 5-10 minutes. Commence procedure immediately thereafter. Analgesic efficacy may decline if the skin application time is more than 5 hours. Procedures on intact skin should begin soon after the occlusive dressing is removed. On the genital mucosa analgesic efficacy declines after 10-15 minutes and therefore the procedure should be commenced immediately. **Children.** ***Skin*** (apply a layer of cream under an occlusive dressing). Prior to small procedures e.g. needle insertion or minor skin operations. Application time: approx. 1 hour. ***Term newborn infants and infants under the age of 3 months (or < 5 kg):*** Up to 1 g on a maximum application area of 10 cm^2. Application time: 1 hour, not more. Only one single dose should be given in any 24 hour period. ***Infants aged 3-12 months (and > 5 kg):*** Up to 2 g on a maximum application area of 20 cm^2. Application time: approx 1 hour, maximum 4 hours. ***Children aged 1-6 years (and > 10 kg):*** Up to 10 g on a maximum application area of 100 cm^2. Application time: approx 1 hour, maximum 5 hours. ***Children aged 7-11 years (and > 20 kg):*** Up to 20 g on a maximum application area of 200 cm^2. Application time: approx 1 hour, maximum 5 hours. A maximum of 2 doses at least 12 hours apart may be given to children over 3 months of age (and > 5 kg) in any 24 hour period. Prior to curettage of mollusca in children with atopic dermatitis, an application time of 30 minutes is recommended. Analgesic efficacy may decline if the skin application time is more than 5 hours. Procedures on intact skin should begin soon after the occlusive dressing is removed. **Contraindications:** Known hypersensitivity to anaesthetics of the amide type or to any other component of the product. **Precautions:** EMLA should not be used in pre-term neonates i.e. gestational age less than 37 weeks, or in infants/neonates between 0 and 12 months of age receiving treatment with methaemoglobin-inducing agents due to the possible additive effects. In infants younger than 12 months a transient, clinically insignificant increase in methaemoglobin level is commonly observed up to 12 hours after application of EMLA. Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methaemoglobinaemia are more susceptible to drug induced methaemoglobinaemia. Methaemoglobinaemia may be accentuated in patients already taking drugs known to induce the condition e.g. sulphonamides. Do not apply to any wounds or mucous membranes, in addition do not apply to genital mucosa in children. Care should be taken when applying EMLA to patients with atopic dermatitis. A shorter application time, 15-30 minutes, may be sufficient. Care should be taken not to allow EMLA to come in contact with the eyes as it may cause eye irritation. Also the loss of protective reflexes may allow corneal irritation and potential abrasion. If contact with the eye occurs, immediately rinse the eye with water or sodium chloride solution and protect it until sensation returns. EMLA may be ototoxic and should not be instilled in the middle ear nor should it be used for procedures which might allow penetration into the middle ear. Caution should be exercised in patients with anaemia, congenital or acquired methaemoglobinaemia or patients on concomitant therapy known to produce such conditions. Patients treated with anti-arrhythmic drugs class III (e.g. amiodarone) should be under close surveillance and ECG monitoring considered, since cardiac effects may be additive. Lidocaine and prilocaine have bacteriocidal and antiviral properties in concentrations above 0.5-2%. For this reason, the results of intracutaneous injections of live vaccines should be monitored. The risk of additional systemic toxicity should be considered when large doses of EMLA are applied to patients already using other local anaesthetics or structurally related drugs e.g. mexiletine. Specific interaction studies with lidocaine/prilocaine and anti-arrhythmic drugs class III (e.g. amiodarone) have not been performed, but caution is advised. Studies have failed to demonstrate efficacy of EMLA for heel lancing in newborn infants. Use with caution in women who are pregnant or breastfeeding. **Undesirable effects:** Common: Transient local reactions at the application site such as paleness, redness and oedema, local sensations (an initial, usually mild, burning sensation, itch or warmth) at the application site when used on genital mucosa. Uncommon: Local paraesthesia such as tingling at the site of application, an initial mild burning or itching sensation at the application site when used on intact skin. Rare: Corneal irritation after accidental eye exposure, methaemoglobinaemia in children - methaemoglobinaemia is more frequently observed in neonates and infants aged 0 to 12 months, often in connection with overdose. Rare cases of discrete local lesions at the application site, described as purpuric or petechial have been reported, especially after longer application times in children with atopic dermatitis or molluscа contagiosa. In rare cases local anaesthetics have been associated with allergic reaction including anaphylactic shock. **Legal category:** P. **Marketing authorisation number:** PL 17901/0120. **Basic NHS cost:** "Pre-medication pack" containing 5 x 5 g tubes EMLA and 12 occlusive dressings £9.75, 1 x 30 g tube £10.25, "Dispensing Pack" containing 1 x 5 g tube £1.73, "OTC Pack" containing 1 x 5 g tube and 2 occlusive dressings – non-prescribable and available through retail pharmacy direct purchase only £2.99. **Further information is available from the Marketing Authorisation holder** AstraZeneca UK Limited, 600 Capability Green, Luton, LU1 3LU, UK. EMLA is a trademark of the AstraZeneca group of companies. AZ 11/08

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Group Editor
Gary Paragpuri MRPharmS
01732 377688
News Editor
Max Gosney 01732 377315
Online Editor
Tom Hawkins 01732 377284
Features Editor
Jennifer Richardson 01732 377088
Reporters
Zoe Smeaton 01732 377441
Chris Chapman 01732 377503
Clinical & CPD Editor
Gavin Atkin 01732 377239
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Acting Marketing Editor
Sarah Thackray 01732 377600
Group Production Editor
Fay Jones 01732 377396
Deputy Group Production Editor
Harriet Kinloch 01732 377112
Group Art Editor
Richard Coombs 01732 377528
Designers
David Farram 01732 377120
Jo Konopelko 01732 377231
Office Manager
Elaine Steele 01732 377621
(fax): 01732 367065
esteele@cmpmedica.com
Marketing Manager
Emily Miles 01732 377612
Commercial Director
Ruth McKay 020 7921 8456
Advertisement Managers
Daniel Spruytenburg 020 7921 8126
Deborah Heard 020 7921 8119
Senior Sales Executive
Andrew Walker 020 7921 8123
Online Senior Sales Executive
Jonathan Franklin 020 7921 8333
C+D Data
Devi Patel (Operations Manager)
020 7921 8235
Colin Simpson (Price List Controller)
020 7921 8667
Darren Larkin (Electronic Data Controller) 020 7921 8294
Sandra Drawbridge (Input Clerk)
020 7921 8674
Projects Director
Patrick Grice MRPharmS
01732 377296
Training Development Managers
Asha Fowells MRPharmS
01732 377463
Kinna McConochie MRPharmS
01732 377487
Projects Administrator
Pauline Sanderson 01732 377269
Production
Katrina Avery 01732 377674
Managing Director
Phil Johnson 01732 377633
Email
firstinitialsurname
@cmpmedica.com

> IF MY MATHS IS RIGHT, IT MEANS TWO THIRDS OF LPCs ARE STRUGGLING TO MAKE ANY HEADWAY WITH THEIR LOCAL PAYMASTERS

You really shouldn't need any research to tell you that more people visit a community pharmacy for health-related needs than any other primary care health service. There are more pharmacies per PCO patch than any other service provider and, judging by the yearly increases in script numbers, they're not exactly standing around twiddling their thumbs.

So why is it that local commissioners invest so little in community pharmacy services when patients find pharmacies so accessible and useful? Just a third of LPCs rate their PCT as good when it comes to commissioning pharmacy services (p5). And if my maths is right, that means two thirds of LPCs are struggling to make any headway with their local paymasters.

Resistance from GPs and a lack of interest and funds from PCTs are cited as top reasons by LPCs as to why pharmacy can't get its foot in the commissioning door. Some fault must also lie with pharmacy though, as over a quarter of LPCs claim contractors have shown little interest in embracing new opportunities. But the potential for pharmacy's contribution is both enormous and real.

Just last month, for example, the associate medical director for NHS East of England (who also happens to be national co-lead of the PBC Federation) highlighted how pharmacy could save the NHS millions of pounds by using MURs as a tool to keep people with chronic conditions out of hospital (C+D, September 12, p4).

And he's not living in a fantasy land; an asthma MUR rolled out by Isle of Wight pharmacists has slashed emergency admissions for asthma by half and seen the number of prescriptions for beta 2 agonists cut by a quarter (C+D, September 26, p31).

With GSK now supporting pharmacists to provide MURs for patients with Parkinson's (p10), the contract's much maligned advanced service is rapidly developing into a mechanism that benefits patients, the NHS and pharmacists alike.

In Scotland the government is expected to announce a two-year finance package for its contractors, which includes funding for national sexual health and smoking cessation services (p4). Is there then not plenty of evidence around to justify the rollout of more nationally funded pharmacy-led services across the UK?

Gary Paragpuri, Editor

RPSGB promises to show leniency to RP rule breakers

EXCLUSIVE Criminal prosecution "not effective", says chief inspector, as rules go live

Chris Chapman
cchapman@cmpmedica.com

Inspectors will adopt a "proportional and appropriate" response to responsible pharmacist (RP) regulation breaches and not look to prosecute genuine errors, the RPSGB has pledged.

Speaking exclusively to C+D, Society chief inspector Sarah Billington reassured pharmacists that breaching the new rules, introduced on October 1, will not result in automatic criminal prosecution.

She said: "The initial regulatory response will be what we currently do, which is to secure compliance through engagement with pharmacists... our first port of call is to consider things as a potential conduct issue, regardless of the fact that they're criminal offences under legislation."

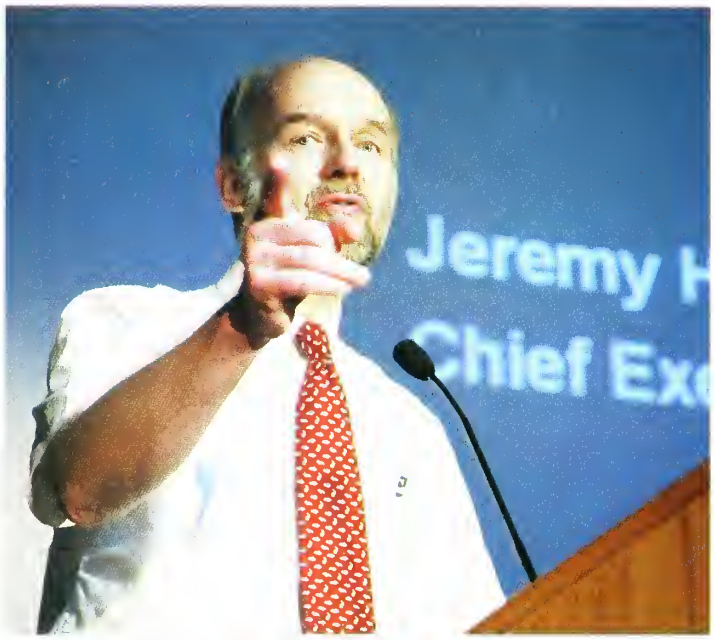
Under strict RP definitions, failing to sign out of a pharmacy at the end of the day could lead to a fine and criminal record. However, Ms Billington said such a response was "not effective" and inspectors would take "a completely different view".

"The heavy-handed approach will be when there is some sort of complaint or allegation involving RP legislation, or when there's been constant non-compliance where we've engaged with organisations and tried to secure compliance, but they're obviously resistant."

Many RP regulation breaches will not even be referred to the Society's investigating committee, Society chief executive Jeremy Holmes said.

He said: "The key driver is patient safety. And that lies behind a lot of the non-referral processes, as where someone makes a genuine omission – is patient safety compromised? That's what we'd be looking at."

Mr Holmes added there had been "a lot of smoke and noise" about the RP regulations, but he believed most pharmacists were prepared for the change.



Jeremy Holmes: we won't refer all regulation breaches to Investigating Committee

Nine out of 10 pharmacists not using RP absence

More than nine out of 10 pharmacists do not plan to take advantage of the two-hour absence now allowed by responsible pharmacist regulations.

The results of this week's C+D Dispensary Talk poll found the majority of pharmacists will not utilise the allowed absence to leave their pharmacies.

Ruth Jones, of JK Lunt pharmacy, Shrewsbury, said it was impractical to be absent for two hours. She said: "On a practical basis, leaving for two hours without accuracy checking technicians will just leave a bigger workload."

Nearly 90 pharmacists completed the online poll.

Pharmacists did not have to use the two-hour absence allowance, the RPSGB stressed, but it provided the chance to deliver services direct to patients and meet GPs.

Overhaul for oxygen service

Home oxygen services will be overhauled after a review questioned the quality only three years after it was withdrawn from community pharmacy.

The DH report revealed a third of patients derived "little or no clinical benefit" from the service. It said there was "scope for improving its convenience and reliability", that companies provided a "fairly limited range of equipment", and that patients with COPD found parts of the service "sub-optimal".

Oxygen services were restricted to four suppliers in February 2006, excluding community pharmacies from the service despite protest from PSNC and C+D's Choice in Oxygen campaign. **CC**

Scots funding package anticipated

Martin Green: a satisfactory deal, but negotiations fell short of aspirations

The Scottish Government was expected to announce a two-year financial package for community pharmacy as C+D went to press this week.

C+D understands that the 2009-11 agreement was set to include:

- an increase in retained purchase profits as part of a new efficient purchasing and prescribing programme
- a cut in discount recovery for branded products to offset recent reductions in available discount
- changes to the generic clawback rate
- retention funding for the national sexual health and smoking cessation services launched last autumn
- an inflationary uplift to the global sum.

Contract negotiator Community Pharmacy Scotland (CPS) could reveal no further details of these agreements ahead of the government announcement, anticipated for Thursday.

But CPS chairman Martin Green told C+D the settlement had been reached after "protracted and at times difficult" negotiations. "This is a satisfactory agreement for contractors but negotiations fell short of our aspirations," he said.

"Considering the current economic climate it was the best achievable for contractor owners at this point in time."

CPS would shortly be announcing a series of roadshows across the country to inform contractors of the package details, Mr Green added. **JR**

LPCs condemn PCT commissioning skills

Only one in three trusts is up to scratch, C+D survey reveals

Zoe Smeaton
zsmeaton@cmpmedica.com

Just one third of LPCs would rate PCTs as 'good' or 'excellent' at commissioning pharmacy services, a C+D survey has found.

The trusts were accused of resisting commissioning and lack of interest. GPs were named as another top barrier to pharmacy progress.

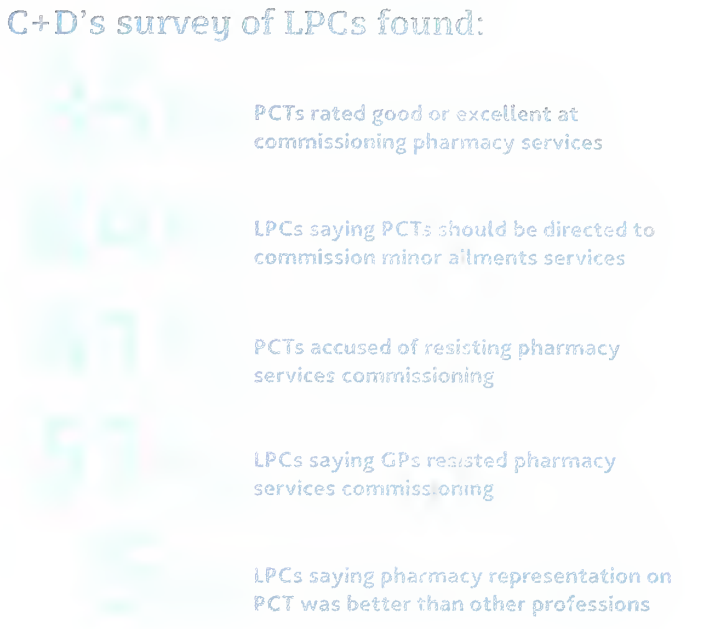
LPCs called for trusts to be directed to commission more services, putting minor ailments services and vascular risk assessments as the priorities.

Industry leaders said they were not surprised by the results, but called on both LPCs and contractors to help boost commissioning as well.

Fifty one per cent of LPCs in the survey said resistance from GPs was hindering commissioning. Over 40 per cent of LPCs blamed resistance from PCTs, and 22 per cent cited a lack of interest from the trusts.

Sixty five per cent of respondents complained that pharmacy was not as well represented as other professions in the trusts.

Jonathan Mason, the DH's community pharmacy tsar, said the survey provided an "interesting snapshot" of where pharmacy was in terms of the relationships needed for commissioning. He said the results should act as "a bit of a reality check".

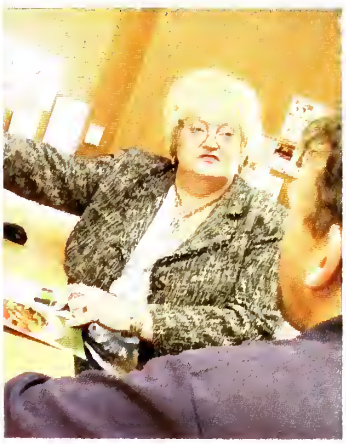


Mimi Lau, director of professional and training services at Numark, said: "GP resistance is predictable. Some still believe it's their money, their PCT and their patients." She said the pharmacy sector needed leadership from a national level to help improve relations with general practice.

Georgina Craig, pharmacy services commissioning network lead at NHS Alliance, said in the future budget cuts would mean PCTs could not afford to be resistant to commissioning pharmacy services. But she advised: "PCTs will be actively looking for solutions that deliver. If pharmacy contractors are up for it, they need to ensure PCT commissioners know that." **ZS**

How can pharmacy improve ties with PCTs?
See p16

Minor ailments tipped for DES



Minor ailments look set to become first pharmacy directed enhanced service

A national minor ailments scheme (MAS) is likely to be agreed as the first pharmacy directed enhanced service (DES), the DH's community pharmacy tsar has said.

Negotiations are ongoing and Jonathan Mason said it was not yet clear how exactly the service would look, but he said it would "take away some of the variability" in current services.

PSNC was known to be in negotiations with NHS Employers on a national MAS, but it was not clear whether that will be funded nationally or set up as a DES.

Mr Mason clarified: "As part of the negotiations between NHS Employers and PSNC they are looking at development of a directed enhanced service for MAS. That was one of the actions in the [pharmacy] white paper," he added.

The news comes as C+D's LPC Survey found minor ailments was the top service local leaders would like to see PCTs commissioning.

In the survey 84 per cent of LPCs said minor ailments should be a priority, with 81 per cent also naming vascular risk assessments and 54 per cent weight management services.

Mr Mason was speaking at an RPSGB seminar on enhanced services at Lambeth this week. **ZS**

MPharm marking issues

Marking irregularities related to the University of Manchester's MPharm module have been uncovered by the RPSGB. The Society's regulatory team found marking had been compromised in one module. However, the university corrected the mistake and academic standards and patient safety were not compromised, the RPSGB said. **www.chemistanddruggist.co.uk**

HPV vaccine recalled

A batch of HPV vaccine Ceravix has been recalled following the death of a 14-year-old girl. Manufacturer GlaxoSmithKline said the recall was a precaution while the MHRA determines if there is any link between the vaccine and the death. Batch no: AHPVA043BB.

Generics guide

C+D's Generics Guide is now available on the C+D data website. Go to **www.cddata.co.uk** to get your copy.

Ask Your Pharmacist

The NPA has declared November 9-15 'Ask Your Pharmacist Week'. The campaign, which will be launched by shadow health minister Mark Simmonds, aims to promote seven pharmacy services, including allergy screening and MURs. **www.askyourpharmacist.co.uk**

PCC recruiting

The Pharmaceutical Contractors Committee (NI) is looking to appoint a new chief executive to replace Terry Hannawin, who is retiring. Applicants must be pharmacists with experience in the community sector and at senior management level. For more information see page 34.

Crazy Chemist launched

The government has launched a new campaign warning against 'legal high' drugs – fronted by a "Crazy Chemist". The FRANK campaign, targeted at 18 to 24-year-old clubbers, aims to highlight the dangers of legal street drugs such as gamma-butyrolactone. **www.chemistanddruggist.co.uk**

Lloyds' boss calls for unity at C+D summit

The MD of Lloydspharmacy will urge community pharmacy to stand united to establish its future role at a landmark industry summit next month.

Richard Smith, who will deliver the message at the C+D Keynote Conference in Birmingham, said: "My view is that all of pharmacy needs to get together with one voice to ensure the future of the market and work out what it is. After that we can worry about dividing it up."

Mr Smith said that pharmacy had to "embrace the need of the government" by providing services, but said that it would be necessary to do so with less money than had been available in the last 10 years. "The days of making a profit purely out of dispensing are over," he added.

The Lloydspharmacy chief will be joined by other top industry figures at the conference, which will give pharmacists practical advice on delivering the next generation of pharmacy services.

Don't miss your chance to attend the C+D Keynote Conference on October 11-12. Register for your free ticket at **www.chemistanddruggist.co.uk/thepharmacyshow**

Prescribing chance missed

Only one in four pharmacist prescribers working in community pharmacy are using their qualification, according to a study.

Colleagues in GP practices were twice as likely to be using their powers, the Centre for Pharmacy Postgraduate Education (CPPE) research found. Community-based prescribers registered high learning needs and lacked the confidence of those in surgeries, the CPPE said.

Overall, prescribers reported low confidence in writing business cases around prescribing. **JC**

Boots to pay employees' PLB fees for first year

Pharmacy needs a 'strong' leadership body, says Boots superintendent

Jennifer Richardson
jrichardson@cmpmedica.com

Boots will pay the future professional body's first year membership fees for all its pharmacists, it announced this week.

The multiple's "ambition" was to support the professional leadership body (PLB) in becoming a member-focused organisation, Boots professional standards director and superintendent Paul Bennett told C+D. "The profession does need a strong PLB."

The decision to pay fees was made by Boots's board and "unrelated" to the company's head of professional practice, Steve Churton, being RPSGB president, he added. Mr Bennett said: "This decision is not one that has been taken by or with the involvement of the president of the Society."

Boots was "expecting" the cost of joining the PLB and the future regulator to together be no more than current RPSGB retention fees plus inflation, Mr Bennett said, something the Society has previously suggested would be the case.

"If it's more we'll have to consider that at the time that fee is published, but we have no reason to believe it's any different to that," he added.

Asked how Boots would decide if it would pay the fees beyond the first year, Mr Bennett highlighted Society pledges for the future body including leadership, representation, advocacy, professional development, education and networking.

"Those are the things the profession will judge the PLB on and Boots UK will be no different," Mr Bennett said.

Boots bags deal to run Waitrose pharmacies

Boots has ramped up its relationship with upmarket supermarket Waitrose.

The multiple is rebranding each of the 13 pharmacies it runs in Waitrose stores as 'Boots Pharmacy', and the two companies have announced their intention to trial selling a "very selective" range of each other's products.

Alliance Boots saw the moves as "an important first step in developing a wider relationship with Waitrose", said health and beauty division chief executive Alex Gourlay.

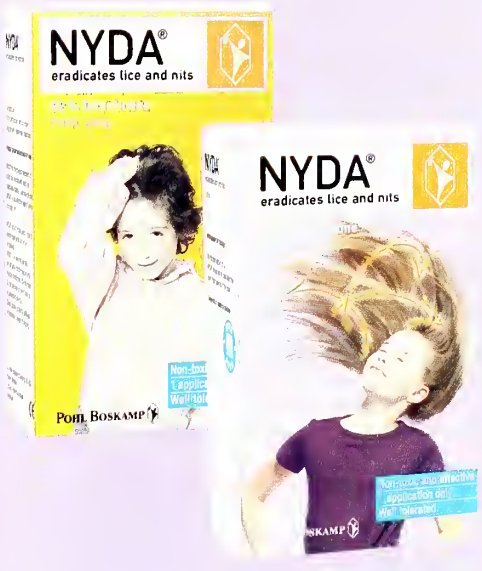
The first of the Waitrose pharmacies opened in 1998 and the 13 are branded either Moss Chemist or Alliance Pharmacy. The contracts have been operated by Boots since the Alliance merger in 2006.

Both companies told C+D they would consider increasing the number of Boots pharmacies in Waitrose supermarkets in the future. Details of the two companies' financial stakes in the pharmacies were "commercially sensitive", they said.

Pharmacy minister Mike O'Brien (pictured left) was updated on stock shortage issues as well as receiving a blood pressure check when he visited a pharmacy in his north Warwickshire constituency last week. Mr O'Brien visited the No 8 Pharmacy in Bedworth and pharmacist Deepesh Soni (pictured right) told C+D: "It was very positive, we were showcasing the services we offer. And we raised concerns with regards to stock issues and emphasised that unfortunately it is the patient at the end of the chain who is having to go without medications." The visit was co-ordinated by the All-Party Parliamentary Pharmacy Group, and Mr O'Brien said it had reinforced the importance of the pharmacy white paper. ZS

Joy Wingfield: The Responsible Pharmacist – the dangers and the rewards

NYDA



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- ✔ Evidence based medicine[3]
- ✔ Well tolerated

Zero discount switch

AAH has removed discounts on several UCB products after the manufacturer applied to reclassify them as Zero Discount from November. UCB had informed wholesalers there would be no discounts on these products with immediate effect, AAH said. See a list of the products at **www.chemistanddruggist.co.uk**

Drug delays Parkinson's

Early treatment with Azilect (rasagiline 1mg daily dose) can slow the progression of Parkinson's disease, according to a study. The research, published in the New England Journal of Medicine, showed newly diagnosed patients who received the treatment had sustained clinical benefits at 18 months compared to patients whose treatment was delayed for nine months.

Bowel cancer hope

A trial has been carried out that shows Avastin (bevacizumab) can shrink tumours that have spread to the liver in patients with bowel cancer, when combined with chemotherapy. As a result, one third of the patients were eligible to undergo potentially life saving surgery, a European Society for Medical Oncology conference heard.

RP training session

Buying group PharmaPlus has held a one-day training session for members to prepare them for the responsible pharmacist regulations. Over 60 pharmacists attended. **www.chemistanddruggist.co.uk**

NCAS study

The National Clinical Assessment Service has released the largest study of UK medical and dental performance concerns. The report found two out of three referrals are about clinical skills, with behavourial concerns also common. **www.chemistanddruggist.co.uk**

Contraception info

Organon, part of Schering-Plough, has relaunched its Talk Choice website. The site aims to boost knowledge of contraceptive choice, and includes several new resources such as FAQs. **www.talkchoice.co.uk**

Ownership rules branded discriminatory by locum

French pharmacist challenges DH ruling on new pharmacies

Zoe Smeaton
zsmeaton@cmpmedica.com

Fosso Taga: applied for a review of the RP rules that prevent him being in charge

A UK-based French pharmacist has challenged the Department of Health (DH) over rules that prevent pharmacists with foreign EU qualifications being in charge of new pharmacies.

Locum pharmacist Fosso Taga, who qualified in France but has worked in the UK for over a decade, said he believed such rules were discriminatory.

Backed by legal experts, he has applied for a judicial review of the regulations and launched a petition with the European Parliament.

In response, the European Commission has contacted the DH to verify whether EU principles are being respected in the way the law is applied in England.

The responsible pharmacist regulations state that pharmacists who qualified in another EU state may not be responsible for pharmacies that have been open for less than three years. The same rule applied previously when considering whether pharmacists could be in personal control of pharmacies.

David Reissner, head of healthcare at law firm Charles Russell, said in his view the three-year restriction on pharmacists registered overseas was hard to justify.

"It is based on European legislation aimed at harmonising laws across the EU, but member states do not all have such a restriction and the DH did not have to make it part of UK law," he said.

An EU directive allows member states not to give "automatic recognition" to qualifications obtained in other states when considering pharmacists to be in charge of new pharmacies. But the European Commission has now stated that this directive should not be used as the sole basis for deciding to refuse to let such pharmacists be in charge of new pharmacies.

Dental regulator chief appointed GPhC head

The head of the General Dental Council (GDC) has been named chief executive and registrar of the future pharmacy regulator.

Duncan Rudkin will take up the post at the General Pharmaceutical Council (GPhC) on January 1, ahead of the regulator being launched in spring 2010.

Mr Rudkin spent over 10 years at the GDC and has been chief executive at the organisation since 2006. He said he was "immensely looking forward" to working with the profession to develop a "positive role" for the GPhC.

Mr Rudkin said the organisation would champion quality and standards in the profession as well as putting patients at the centre of its work.

Mr Rudkin joined the GDC in 1998, previously holding the posts of director of legal services, director of professional standards and deputy chief executive, after working as a solicitor in the City of London.

Duncan Rudkin: looking forward to developing a positive role for the GPhC

GPhC chair designate Bob Nicholls said: "We are fortunate in having a chief executive and registrar of this calibre and experience." **JR**

Fuel surcharge to make return

Alliance Healthcare will bring back fuel surcharges to orders from October 1 in the face of rising forecourt prices.

The wholesaler will apply a mandatory £2.50 charge as national pump prices stay well above the £1 per litre mark.

John Geddes, Alliance Healthcare sales director, said: "For as long as possible we have made every effort to ensure that we did not pass these costs on to customers. However, we are now required to raise the charge to £2.50, to ensure that we can continue to provide the high levels of service our customers expect."

Alliance Healthcare joins fellow wholesaler Phoenix in operating a fuel tariff. AAH said it did not currently apply a fee.

The surcharge will be reviewed on a month by month basis, Alliance Healthcare said. **JC**

NiQuitin® Minis
Mint 4mg lozenges
nicotine

NEW

Not big. But very clever.

Pack shown actual size

NiQuitin® Minis release their full dose of therapeutic nicotine how many times faster than Nicorette gum?*

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- **B:** They are the same
- **C:** Twice as fast
- **D: 3 times faster**

*Speed of release in the mouth does not imply speed of craving relief

NEW small NiQuitin® 4mg Minis provide fast craving relief within minutes,[1,2] and are designed especially for those smokers who know they should quit, but want to do it at their own pace.

Make a clever choice and recommend NiQuitin® Minis to help them quit one cigarette at a time.

Help them quit one cigarette at a time

GlaxoSmithKline
Consumer Healthcare

NiQuitin Minis Mint 1.5mg/4mg Lozenges (nicotine). Indication: smoking cessation. **Dosage:** *Adults (18 and over)*: Max 15/day. One lozenge whenever urge to smoke to aid complete cessation (taper use after 6 weeks) or gradual cessation (seek advice if no reduction after 6 weeks or no abrupt attempt after 6 months). Use 1.5mg strength if smoke ≤20/day. *Adolescents (12-17 years)*: Abrupt cessation only. Dosing as for adults but seek professional advice if >12 weeks treatment required/unable to quit abruptly. **Contraindications:** Hypersensitivity, non-smokers, children under 12 years. **Precautions:** Risk of NRT substantially outweighed by risks of continued smoking in virtually all circumstances. Supervise use in those hospitalised for MI, severe dysrhythmia or CVA who are haemodynamically unstable. Once discharged, can use NiQuitin as normal. Susceptibility to angioedema, urticaria. Renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma. Swallowed nicotine may exacerbate oesophagitis, gastric/peptic ulcer. Pregnancy/lactation: For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. **Side effects:** At recommended doses, NiQuitin Mini Lozenges have not been found to cause any serious adverse effects. Nausea, hiccup, flatulence, GI discomfort, vomiting, diarrhoea, dyspepsia, fatigue, malaise, chest pain, oral irritation, dizziness, headache, sleep disorders including abnormal dreams, anxiety, irritability, nervousness, depression, palpitations, increased heart rate, cough, sore throat, rash. See SPC for full details. GSL PL 00079/0610, 0611. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack sizes and RSP:** 20's £4.99, 60's £13.99. **Date of preparation:** June 2009. **NiQuitin®, NiQuitin® Minis** and the **Minis Device** are trademarks of the GlaxoSmithKline group of companies.

MyPharmAssist.co.uk
The Online Pharmacy Community

References: 1. Durcan MJ *et al.* Efficacy of the nicotine lozenge in cue-provoked cravings. 66th Annual Meeting of College on Problems of Drug Dependence; San Juan, P.R., 2004. 2. GSK data on file.

Dispensary talk

How will you spend your two-hour RP absence?

"The way it works at the moment, I'm going to be on the premises anyway. So it won't have much affect for us here."
Gurminder Sall, Jeeves Chemist, Iver Heath, Buckinghamshire

"I might actually think about doing MURs for housebound patients. That's probably the most productive thing to do."
Raj Patel, Mount Elgon Pharmacy, Wimbledon

Web verdict

Meeting with GP/PCT 1%

In training 4%

Other 3%

Not planning to leave 92%

Armchair view: Fewer than one in 10 pharmacists will be taking advantage of the two-hour absence introduced this week, with the vast majority of respondents staying in the pharmacy.
Next week's question: When was the last time you got a performance review from your boss? Cast your vote at **www.chemistanddruggist.co.uk**

GSK launches support for Parkinson's MURs

EXCLUSIVE Pilot will run in 10 branches but could go nationwide

James Clegg

Tims and Parker pharmacies will receive Parkinson's training from a specialist nurse

GlaxoSmithKline (GSK) has teamed up with 10 Manchester pharmacies to support MURs targeted at Parkinson's disease sufferers, C+D can exclusively reveal.

Pharmacists at branches of regional multiple Tims and Parker will brief patients on how to better manage their condition from next month. The scheme aims to deliver improved medicine compliance and identify Parkinson's sufferers that have failed to see a specialist in the past year, GSK said.

Kimberley Warren, head of GSK pharmacy support programme PLUS, said: "To the best of our knowledge no one has done a Parkinson's disease MUR before. We think it is important to look at long-term conditions and that pharmacy is perfectly placed to do so."

The MURs will be paid for by the NHS, under the £28 pharmacy contract fee. GSK will pay for training support. This includes guidance from a specialist Parkinson's nurse and a pharmacist independent prescriber before offering the service.

The pilot will run for six months with monthly reviews to monitor patients' progress, after which GSK could look to possible national rollout.

Pharmacists will get patients to rate how well the NHS has managed their condition by completing a survey during the MUR. Participants will also get information packs on their medication and Parkinson's.

The MUR service was developed by Tims and Parker professional service manager Paul Benson, GSK and Parkinson's disease charities.

The pilot had huge potential according to Daiga Heisters, national education advisor at the Parkinson's Disease Society. "With the right information, pharmacists should feel confident that offering this kind of support could make a real difference to the quality of life of someone with Parkinson's, so we can't wait to see the outcomes of this pilot," she said.

The MUR will cover all Parkinson's medicines and not just GSK products, the manufacturer said.

Customers fight for East End pharmacy

The fate of an East London pharmacy hangs in the balance, despite the support of over 500 customers.

Taisia Pianov is being forced to move from her pharmacy, Mayors Chemist, to make way for a new development in Bow.

She has found new premises but is awaiting a decision from Tower Hamlets PCT on whether she can transfer her NHS contract.

Initially, Mrs Pianov applied for a minor relocation, but the PCT disputed this. Tower Hamlets PCT said that for a minor relocation to be approved, both the current and proposed premises have to be within the same neighbourhood. The proposed premises was in a new neighbourhood because Bow Road acted as a physical boundary and the nature of the area was significantly different from the existing location, the PCT said.

Initially the local housing association in charge of the regeneration, Eastend Homes, offered to re-house displaced retailers in new business units nearby. However, Mrs Pianov claims that the rent was over three times what she is currently paying.

She said: "Our customers are very concerned and that's why so many of them have signed a petition.

"We can't win against Eastend Homes so we can only stay in the area when the PCT make a decision."

Eastend Homes said: "We believe we have done everything we can to reach an amicable settlement." **JC**

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Contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey GU1 4YS. Fax number 01483 554831. Date of Preparation August 2009 STW 382

Bepanthen in a wipe for busy mums

Bayer Healthcare is introducing wipes into its Bepanthen range as a portable option to help busy mums care for their babies when changing nappies 'on the go'.

Bepanthen wipes contain Pro Vitamin B5 to aid the skin's natural recovery and are formulated to help keep babies' delicate skin soft, smooth and moisturised.

Once a baby's bottom is clean, the wipe is squeezed to release the lotion, which can then be gently wiped over the sensitive area.

The wipes are free from fragrances, preservatives and colours. Bayer says the product is gentle enough to be used at every nappy change.

The launch will be supported by marketing activity, which includes sampling and competitions in the parenting press and online.

Price and Pip code:
£2.99/12, 347-0853
Ceuta Healthcare
Tel: 01202 702558
www.bepanthen.co.uk

Market focus

- The £20.7 million nappy care ointment/cream market is growing at 4.2 per cent year on year.
- Bepanthen is currently the fastest growing brand in this market, growing at 35.4 per cent year on year.
- Bepanthen is the No 2 brand in this market with a 22 per cent market share.

Source: IRI value share in all outlets 52 w/e 11 July 2009

DVD to dye for

Nature's Dream is to distribute an interactive DVD to stockists of its Naturtint hair colorant range. The resource demonstrates how to use the products safely and effectively and offers ideas from top colourist Marc Ramos. This year will see a £150,000 consumer ad campaign, which will be stepped up in 2010.
Nature's Dream
Tel: 0845 601 8129
www.naturesdream.co.uk

Scalproller for the home

Pangaea Laboratories is introducing a home version of its Nanogen microneedle therapy professional roller treatment to help treat thinning hair. The Scalproller has titanium needles designed to penetrate the skin with minimal irritation to improve the effects of a topical hair loss treatment. The Nanogen range is approved by the Alopecia Society.
Price: £47.95
Pangaea Laboratories
Tel: 0208 458 2500
www.nanogen.co.uk

Afinitor launch

Novartis Pharmaceuticals has launched Afinitor tablets (everolimus) for the treatment of patients with advanced renal cell carcinoma whose disease has progressed on or after treatment with VEGF-targeted therapy.
Pip code: 5mg/30, 348-2197; 10mg/30, 348-2189
Novartis Pharmaceuticals UK
Tel: 01276 692255

Ahava adds sparkle to Xmas

Ahava is launching two new Dead Sea mineral skincare gift packs in time for Christmas.

The Mineral Sparkles set combines four Dead Sea Mineral products in an attractive gift box. It includes Pure Dead Sea Bath Crystals, Pure Dead Sea Mineral Mud, Pure Body Sorbet Caress and Purifying Mud Soap.

The New Year, New You gift set is a versatile zipped make-up box containing Pure Dead Sea Liquid Salt, Pure Uplifting Butter Salt and Pure Body Sorbet Caress.

Prices: Mineral Sparkles £20; New Year, New You £45
Ahava UK; tel: 01452 864574
www.ahava.co.uk

Vichy helps protect skin

Vichy Laboratoires has developed a new skincare range that contains the antioxidant Pure Citrus Polyphenol to help protect skin from oxidation by environmental aggressors.

The Aqualia Antiox range includes Pro-Youth 24h Hydrating Fluid SPF 15 UVA, a hydrating fluid suitable for normal to dry skins, and Pro-Youth Anti-Fatigue Stick, which has a cooling effect to help refresh and revitalise the eye contour area.

A third product, Pro-Youth Fresh Treatment, is an intensive antioxidant treatment exclusive to Boots.

Prices: Fluid £16.00/40ml, Stick £14/4ml
Cosmetique Active UK
Tel: 020 8762 4030

New-look Clotam Rapid in stock

Galen has repackaged its NSAID Clotam Rapid, which is now back in stock.

Clotam Rapid (tolfenamic acid 200mg) is licensed for the relief of acute migraine attacks.

The new packs are branded in red and black and are designed to be easier to read than the original design. The formulation of the tablets remains unchanged.

Galen apologises for any inconvenience that the product's out of stock situation has caused.

Price: £15/10, 241-1569
Galen
Tel: 028 38 363613

Calpol On TV next week

Hedrin: five, GMTV, Sat
Levonelle: All areas
Oral B Rechargeable toothbrushes: All areas
Oxy: All areas
PharmaSite for next week: Oilatum – windows, **Oilatum** – in-store, **Oilatum** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Commitment 3:

We will positively encourage professional networking and the sharing of knowledge.

On the 7th September we announced a series of commitments that underline how the professional leadership body (PLB) intends to become the body you have asked for.

Our third commitment is to 'positively encourage professional networking and the sharing of knowledge'.

Here are the actions we will take over the next 100 days to demonstrate our commitment:

- We will build an online communications network for pharmacists and test with trial groups.
- We will appoint 5 dedicated Local Practice Forum (LPF) Facilitators to actively promote and support the establishment of the new LPFs, in preparation for every PLB member having access to an active or virtual LPF by April 2010.
- We will provide the opportunity for every member to attend an LPF engagement event in their locality during October and November.

To keep an eye on our progress, suggest future actions we can take, and to read about the rest of the commitments in full, visit **www.pharmacyplb.com**

COMMITMENT TO PHARMACY

"A pharmacist can only really develop fully if they engage and network with their peers. We shouldn't be working in isolation and it is good to know that the new body is committing to providing the professional networking resources that is required to help achieve this."

Finlay Royle,
Clinical Pharmacist

RPSGB is working with the profession to build a new professional leadership body for pharmacy

www.pharmacyplb.com

Is pharmacy getting its fair share?

Just one third of LPCs would rate their local PCT as good at commissioning pharmacy services, a C+D survey has found. **Zoe Smeaton** asks: how can pharmacy improve its lot?

Commissioners failing to respond, PCTs dithering over decisions and patchy commissioning of services are common pharmacy complaints. And a C+D LPC survey has done little to ease fears – of 37 responses, just 35 per cent of PCTs were rated as good or excellent at commissioning pharmacy services. The finding echoes other industry conclusions. PSNC, for example, says poor commissioning is limiting pharmacy's ability to develop white paper services. So what can we do about it?

At least some of the blame must fall on the PCTs. In C+D's survey, resistance from PCTs was named by 41 per cent of LPCs as a barrier to commissioning. And as Sue Sharpe, PSNC's chief executive, recently concluded: "In far too many cases the commissioning of services is held back by PCTs' flawed internal processes."

Some suggest a solution must come from a higher authority. They say more pharmacy services must be nationally agreed. LPCs in the survey identified minor ailments services and vascular risk assessments as the areas they would most like to see their PCTs directed to commission, attracting votes from 84 per cent and 81 per cent respectively. As one LPC put it: "There should be a national benchmark. Currently there is a duplication of talks up and down the country."

Others look to the government's World Class Commissioning framework, which sets out a vision for PCT commissioning. Jonathan Mason, the Department of Health's community pharmacy tsar, hopes the framework will improve PCTs' capabilities, and says given its early stage, to see a third of PCTs already rated as good is "promising". But others are more cautious. Mimi Lau, director of professional and training services at Numark, warns changes will take time. "As a policy it's great, but it's down to the execution... how is that going to be monitored?"

Even if the DH does force some change, though, pharmacy needs to help itself, too. Part of the problem could be due to a lack of understanding of what pharmacy can offer within PCTs. Just 5 per cent of respondees to C+D's survey thought pharmacy was better represented in the PCT than other healthcare professions, with 65 per cent saying it was worse off than others.

There has already been some progress on this, as C+D last week revealed that 72 per cent of PCTs have now appointed a pharmacy specialist at board level. But there is more to be done, and Ms Lau says it is down to LPCs to keep pushing to get that influence in PCTs.

LPCs could hold the key to improving pharmacy's lot in more ways than one, say some. As well as building those all-important relationships with PCTs, they should be developing links with GPs. Over half of LPCs in the survey named resistance from GPs as a barrier to getting services commissioned. But Mr Mason suggests joint working between LPCs and LMCs can make all the difference, and he warns some LPCs need to be more flexible on this. As Ajit Malhi, head of marketing services at AAH, suggests: "Some GPs don't understand the part pharmacy can play and that's a role for LPCs, to change that mind set."

But Mike Holden, chief officer at Hampshire & Isle of Wight LPC, says it is not all down to LPCs. "There is no point the LPC having a relationship with commissioners and with the LMC if pharmacists at the coal face who are going to be delivering services haven't got those relationships as well," he says. "We need GPs and pharmacists working together too."

This lack of enthusiasm from pharmacists locally has certainly been an issue, with 27 per cent of LPCs in C+D's survey citing it as a barrier to commissioning. One said their PCT had been keen to commission services, "but uptake from contractors has been poor and considerable sums have been returned to central PCT funds, which is very frustrating".

Alastair Buxton, head of NHS services at PSNC, says we can't always blame contractors for this: "There is a lot of change going on within pharmacy... there's a lot for pharmacists to deal with so I can understand why sometimes people are not fully motivated."

And things could be set to improve. PSNC is in negotiations to secure extra national services and the parliamentary health committee is holding an inquiry into commissioning, which could lead to changes. It is clear everyone has their part to play in getting the best for pharmacy, but if they all do that properly, perhaps there will be some good news. As Ms Lau concludes: "We can't just sit back and let things happen, we need to be more proactive."

The barriers to commissioning services

LPCs were asked what barriers to commissioning existed in their areas

- **Resistance from GPs: 51 per cent**
- **Resistance from PCTs: 41 per cent**
- **Lack of interest from contractors: 27 per cent**
- **Lack of PCT funds: 22 per cent**
- **Lack of interest from PCTs: 22 per cent**
- **Pharmacy under-represented at PCT level: 5 per cent**

Source: C+D Survey of 37 LPCs in England 2009

Calling all LPCs: want to be involved in future C+D surveys? Email us your contact details

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A breath of fresh air

A CUSTOMER ASKED IF SHE HAD ANY MATES AND SHE THOUGHT HE WAS ASKING ABOUT HER SOCIAL CIRCLE

A new member of staff started last week and it has reminded me why I fell in love with pharmacy all those years ago.

Jean wanted to cut her hours back because of family commitments so we've taken Eileen on for 15 hours a week. I like to spend as much time with new starters as possible to make sure the fundamentals are firmly in place as early as possible. It also does me good to get back to basics and remind myself of how the pharmacy world looks to outsiders.

Eileen has worked in a shop before but not a pharmacy. Her sense of bewilderment and amazement at the sheer number of products on offer and potential knowledge to be gained reminds me of my first time in a pharmacy. Eileen isn't aiming for the encyclopaedic knowledge that I was, but her excitement at becoming an important source of local health advice is palpable.

Eileen reminds me of all the things it's so easy to take for granted, with comments like: "I can't believe you know all your customers' names", and "how would some of these old people manage without you?" She also reassures me that I'm not completely paranoid, saying: "Why isn't the surgery more co-operative?" and "people get very impatient over their prescriptions, don't they?"

Eileen is a little wary about taking on what she rightly sees as a hugely responsible role. I reassure her that, as long as she follows the protocols and asks when not sure, she will be fine. A little anxiety shows someone being challenged, and it is challenges like this that keep people interested. I remember such moments – my first MUR or my first meeting with the local GPs, for example – as landmarks in my professional development.

Margaret and Jean have been great in taking Eileen under their collective wing. Despite having escaped formal training due to their many years of experience under the grandparent clause, their wisdom and knowledge is second to none.

But the bit that Eileen likes most is also one of my favourites – feeling a foot taller when you know that you've really made a difference. She was over the moon when a patient came back to tell her that the antihistamine she had recommended had cleared up their rash.

We've all had a good laugh over some of our more eccentric customers' habits. Poor Eileen was part of the joke following the confusion when a customer asked her for some 'iridescent' co-codamol tablets. She also had to endure some character building embarrassment when a customer asked if she had any Mates and she thought he was asking about her social circle.

I'm sure Eileen will be a valuable addition to our healthcare team. I only wish I had more time to share in her 'bright eyed and bushy tailed' enthusiasm.

Subsidiarity: why PSNI should survive

Subsidiarity is a big word and an important idea. Subsidiarity is a key principle underpining the modern European state and the USA but in addition to being a political principle it is also a moral principle. It is right, proper and ethical to practice subsidiarity and to ensure that it be practised. The world is a better place when nations commit to this principle and in so doing allow people locally to make decisions about the things that directly affect their lives. In this way friction between communities and the state are diminished; particularly the kind of friction that leads to social isolation, political disquiet and the creation of things that people fight about.

If DHSSPS has its way pharmacists in Northern Ireland will, from next year or as soon as is legally practical, be regulated as part of the General Pharmaceutical Council. For DHSSPS there is a lot of sense in this. With the machinery of an organisation set up to regulate 45,000 pharmacists, adding another 2,000 is of little consequence. Regulation of pharmacists and premises will be smoother too with only one body deciding on issues such as fitness to practise. In bigness it seems DHSSPS sees greatness.

That may be, but the principle of subsidiarity suggests otherwise. It suggests that power over decision-making should be handed down the chain of government to the lowest possible grouping that can efficiently undertake the role. Following this reasoning professional regulation of pharmacists in Northern Ireland is best undertaken by a properly reconstituted PSNI with sufficient input from the public we serve.

This is of particular importance now. DHSSPS is currently, in a half-hearted way, tinkering with the 1976 Pharmacy Order, putting in place a few sticking-plaster changes that will merely allow PSNI to continue as a regulator into 2010 and perhaps beyond but these changes to the Order will be of no significance, making a handover of regulation to the GPhC inevitable around 2011 or 2012.

Over the past few months the statutory committee, with its majority of lay members, has proved competent in exercising its responsibilities in protecting the public and ensuring continued public confidence in the profession. It has had no problem removing from the register members who are found lacking and in doing so articulating why this was necessary to protect the public.

With its professional forum proposal out for consultation, PSNI deserves pharmacist support and a real chance at retaining its role into the future and the principle of subsidiarity supports this too.

Terry Maguire is a community pharmacist in Northern Ireland

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03.10.09

Features

Update

Your weekly CPD revision guide

Basic pharmacokinetics

The second of two articles looks at the metabolism and excretion of medicines

Dr Russell Greene MRPharmS

An earlier article (C+D Update, August 8, 2009) discussed how drugs enter the body and are distributed to the receptor site; this article covers how they are removed, or 'cleared'.

When a foreign chemical (eg a drug) has been absorbed the body attempts to eliminate it as rapidly as possible. If the drug is highly hydrophilic it is eliminated by the kidney without the assistance of the liver (eg gentamicin). Otherwise it will need chemical modification to increase its hydrophilicity (eg morphine, propranolol); often this will also reduce its pharmacological activity and potential for distribution to the site of action, whether or not the modified drug is still active.

Metabolism

Most drugs undergo some degree of metabolism, but for highly hydrophilic molecules this may be minimal. Metabolism proceeds in two phases, although not all drugs undergo both and for some the order may be reversed.

Phase one

First there is direct modification, usually by oxidation, hydrolysis or decarboxylation. As well as increasing its hydrophilicity, this usually deactivates the drug, although in some cases metabolism may actually render it more active (eg codeine to morphine) or can activate a previously inert compound (eg enalapril). The cytochrome P450 (CYP) family of enzymes facilitates metabolism. There are numerous isoenzymes within this group that metabolise different drugs. For example, CYP2C19 is responsible for metabolising amitriptyline, cyclophosphamide, diazepam and omeprazole, among others. Cytochromes are present mainly in the liver, but also occur in the gut wall.

Pharmacogenetic differences in the activity of these enzymes are seen in individuals and ethnic groups, and their activity may be reduced by liver disease, or inhibited or induced by certain drugs, causing interactions.

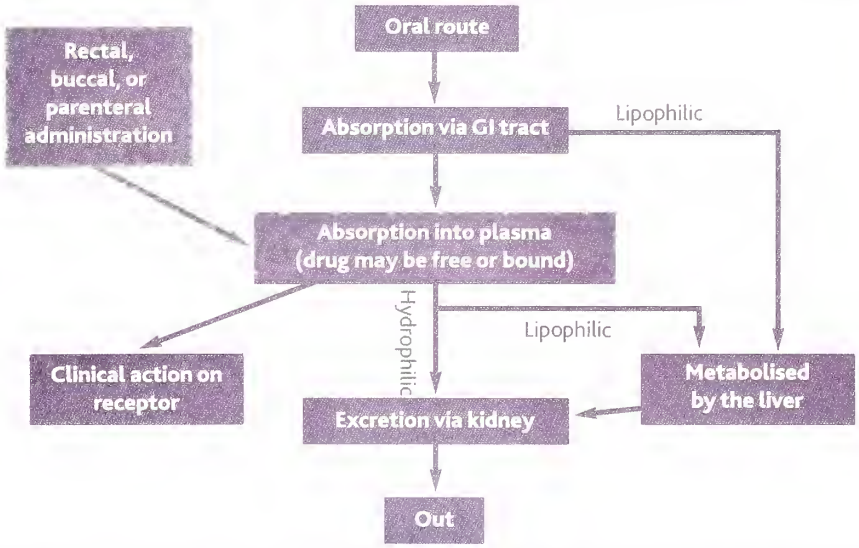
Phase two

The second stage, conjugation, adds water-soluble side chains to the drug: the most common is glucuronic acid (eg for paracetamol), but acetylation and methylation also occur. This further facilitates renal or biliary elimination.

First pass metabolism

Certain very lipophilic drugs are avidly extracted

Figure 1. Drug disposition: overview of drug handling



60-second summary

How are most drugs metabolised?

Direct modification (oxidation, hydrolysis or decarboxylation) facilitated by CYP P450 enzymes makes the drug more hydrophilic so it can be excreted by the kidney. Addition of water-soluble side chains (conjugation) further helps renal or biliary elimination. Age, genetics and liver disease can affect these processes although liver disease has a less predictable effect on metabolism than kidney disease has on excretion.

... and excreted?

Hydrophilic drugs are excreted by the kidneys, mostly by glomerular filtration, so measuring the GFR can help with dose modifications in kidney disease. Lipophilic drugs are filtered to the same extent but are reabsorbed by the kidney tubules, so liver metabolism is needed to make them more hydrophilic. These principles have practical applications for drug use in patients with liver and kidney failure.

This article (module 1497) can help in the following CPD competencies:
C1a, G1c, G7d, C1a, C4f
See http://tinyurl.com/68ox7b

and metabolised by the liver directly after GI absorption, ie before reaching the general circulation (see Figure 1). For drugs like GTN this can be so extensive as to destroy any useful clinical activity, while for others it just reduces bioavailability. However, blood from the buccal cavity or rectum flows directly into the circulation, avoiding the liver, so this first-pass effect may be circumvented by using formulations such as buccal sprays or suppositories.

Factors affecting metabolism

Age Liver function declines with age, but the decline is less predictable and harder to quantify than declining renal function, and its effect on drug metabolism is less clinically significant. Liver function is also underdeveloped in the very young.

Genetics The best known pharmacogenetic difference in metabolism is reduced acetylation, resulting in the slower metabolism of such drugs as hydralazine, captopril, codeine and metoprolol that occurs in about 10 per cent of Caucasians and in lower proportions of other ethnic groups. In addition, the metabolism of certain drugs (notably anti-arrhythmics and psychotropics) may vary considerably between individuals, which often accounts for different dose requirements.

Disease Different forms and extents of liver damage can affect metabolism in unpredictable ways, but drug metabolism is generally only significantly depressed in severe hepatic impairment.

Interactions

The fact that drug metabolism uses only a few common mechanisms for almost all drugs means it is the source of many drug-drug interactions. A number of drugs, in addition to being metabolised, can have direct effects on the enzymes themselves: the enzyme may be either induced (ie, more is synthesised, increasing its activity), or it may be inhibited (blocked). For example, carbamazepine induces CYP2C19 and cimetidine inhibits it.

This may be significant if a patient maintained on, eg an antihypertensive, an antidiabetic or an anticoagulant then receives a second interacting drug. The result may be dangerous underdosing (eg risking thrombosis if warfarin metabolism is induced) or augmentation (eg risking hypoglycaemia if glibenclamide metabolism is inhibited). However, any potential interaction has to be interpreted carefully in the clinical context each time; always consult the BNF Appendix 1. Common enzyme inhibitors and inducers are listed in the earlier Update article on Factors affecting prescribing (C+D, May 16, 2009, online Table 4).

Drugs in liver failure

Liver failure may be due to a variety of underlying diseases and standard 'liver function tests' do not give a precise indication of how the malfunction will affect drug metabolism. Therefore, rational and precise dose modification is not usually possible in hepatic impairment so always consult the BNF Appendix 2. However, a number of guidelines for using hepatically metabolised drugs in liver failure should be followed.

- Avoid drugs causing hepatoxicity (eg paracetamol).
- Is the drug necessary? Is there a renally cleared alternative?
- What proportion of the drug is normally cleared hepatically (how much is excreted renally)?
- Consider whether reduced plasma protein levels found in liver disease will affect drug binding.
- Consider whether the presence of ascites (also commonly found in liver disease) will affect drug distribution of hydrophilic drugs.
- In jaundice, biliary excretion may be reduced.

Excretion

Hydrophilic drugs and metabolites are excreted by the kidney. Renal excretion is primarily by simple filtration in the glomerulus and so the rate of excretion is closely related to the glomerular filtration rate (GFR or creatinine clearance). Consequently the effects of impairment of renal excretion are far more predictable and easily quantified than impairment of hepatic metabolism in liver disease. Note that lipophilic drugs are filtered to the same extent but are almost entirely reabsorbed via the lipid-like membranes in the renal tubules, so overall clearance is very low. This is why these drugs require hepatic metabolism before clearance can take place.

Active secretion of drugs into the tubules is a further elimination route for a minority of drugs (eg penicillins). This can underlie some drug interactions, eg NSAIDs can reduce secretion of methotrexate. In the early days of penicillins, patients were given probenecid along with their antibiotic: probenecid reduced the tubular secretion of penicillin, prolonging its half-life and thus conserving the expensive new treatment.

Another interaction involving this mechanism is the augmentation of lithium levels by thiazide and loop diuretics. The sodium and water loss promoted by these diuretics causes some compensatory increase in sodium reuptake in the tubules, and extra lithium is taken up by the same re-uptake mechanism. Initiating a diuretic in a patient stabilised on lithium can therefore lead to dangerous intoxication.

Urine pH will affect the excretion of acids or bases (alkalis) into the tubules. This is the basis of forced acid or forced alkaline diuresis in poisoning. If aspirin (an acid) has been overdosed, alkalinising the urine (eg with potassium citrate) will speed the excretion of aspirin. Conversely, ammonium chloride can be used to acidify the urine and hasten the excretion of basic drugs, which includes many of the psychotropic drugs frequently involved in overdoses.

Biliary clearance

Some hydrophilic drugs or metabolites (mainly of higher molecular weight) are excreted directly from the liver into the bile (eg rifampicin). However, they may then be reabsorbed from the gut, prolonging the half life of the drug. This may follow a reversal of phase two of metabolism (conjugation) by gut flora.

Factors affecting renal excretion

GFR The GFR is the prime consideration and is usually estimated from measurement of the serum creatinine using a standard formula that adjusts for age, weight, gender and ethnic group.

Drug clearance is reduced in direct proportion to the fall in GFR. If GFR is 50 per cent of normal, clearance of a drug cleared entirely by renal excretion (eg gentamicin) will likewise fall to 50 per cent of normal, and this can be used to modify dosages accurately. However, for many drugs the BNF recommends simple classification of renal impairment as mild, moderate, severe or end stage, based on broad ranges of GFR (BNF, Appendix 3), and makes dose adjustment recommendations on that basis. More precision would only be required for potentially toxic drugs with a narrow therapeutic index (eg digoxin).

Age Renal function declines steadily with age, and the elderly may have a GFR well under half normal. This will reduce drug clearance and is one of the main reasons for reduced dosage in the elderly. Of course, it will only be relevant for drugs excreted mainly unchanged by the kidney.

Disease Renal impairment and renal failure may be caused by numerous diseases (eg glomerulonephritis, diabetes, pyelonephritis, hypertension, etc), but unlike liver impairment, renal impairment usually follows a uniform pathological process with predictable functional impairments, regardless of the underlying disease. Further, impairment can be quantified quite precisely by a single parameter, the GFR.

Mixed clearance modes

Many drugs are cleared partly by hepatic metabolism and partly by renal excretion, eg digoxin is 25 per cent metabolised and 75 per cent excreted unchanged. This must be considered when estimating the effect of hepatic or renal impairment on dosage.

Drugs in renal failure

As usual, appropriate references should always be consulted, eg BNF Appendix 3. The general principles to consider are as follows:

- Avoid nephrotoxic drugs.
- Is the drug or active metabolite cleared renally?
- Is there a hepatically cleared alternative?
- What proportion of the dose is normally cleared renally (some may be metabolised)?
- What is the degree of renal impairment?
- Does the drug have a narrow therapeutic index or are moderate increases in plasma level not clinically significant?
- If the dose has to be reduced, is it better to reduce the frequency or the dose unit?

Russell Greene MRPharmS is a former senior lecturer in clinical pharmacy, King's College London.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.

References and useful contacts are available online at www.chemistanddruggist.co.uk/update

NEXT WEEK

The second in a series on drug misuse, covering the treatment of opioid addiction

Basic pharmacokinetics

What effect does age have on drug metabolism? What factors should be considered when prescribing in liver disease? Why is glomerular filtration rate a good indication of renal excretion?

This article describes how drugs are metabolised and excreted. It includes information about the factors affecting metabolism and excretion, and the effects of liver and kidney failure on drug prescribing.

Read the previous Update articles in this series: Factors influencing prescribing (C+D, May 16, 2009, p16-18, at http://tinyurl.com/mjehdc) and Basic pharmacokinetics: Absorption and distribution (C+D, August 8, 2009, at http://tinyurl.com/l8dyee) if you have not already done so.

The Merck Online Manual has more detailed information about metabolism (http://tinyurl.com/lr5s3j) and excretion (http://tinyurl.com/muhqhn), including a table of common substances that interact with cytochrome P450 enzymes.

Find out more about drug prescribing in renal failure from the Patient UK website (http://tinyurl.com/nnlfj2).

Revise your knowledge of prescribing in liver and renal disease from the BNF Appendices 2 and 3.

Are you now confident in your knowledge of metabolism and excretion? Are you familiar with factors that affect them? Do you know the principles to be followed when prescribing in liver and renal failure?

5 minute test

What have you learned?

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Practical Approach

Getting relief from itchy legs

At the Update Pharmacy, a middle-aged woman has asked for antihistamines for itchy legs and has been referred to pharmacist David Spencer.

"I think I must have become allergic to something," the woman explains, "because in the last few weeks I've been getting this strange feeling in my legs. I call it an itch but it's not really, it's more like a feeling of insects crawling around inside them, and I just have to keep moving my legs around to relieve it. It's actually worse at night and giving me trouble sleeping. That's why I thought one of those antihistamines that also cause drowsiness might be what I need."

"Tell me," says David, "do you have any other symptoms or suffer from any long-term illnesses or take any medicines, including any you've bought over the counter?"

"No, no other problems, no illnesses and I don't take any medicines at all."

"Well," says David. "I think I know what your problem might be. It's not an allergy and taking antihistamines would probably make it worse. There are medicines that can help, but they are all on prescription so you would have to see your doctor to get them, which is what I would recommend anyway."

Questions

1. What is this woman's condition likely to be?
2. What is/are its cause(s)?
3. What are the diagnostic criteria?
4. What are the main pharmacological treatment options?
5. Are there any drugs that can exacerbate the condition?

Answers

1. Restless legs syndrome (RLS). Occurrence is relatively common – prevalence from 3 to 9 per cent, generally increasing with age but up to one third develop symptoms before age 20. RLS occurs more frequently in women than in men.
2. Not fully understood but it involves the dopamine system as dopamine agonists relieve the symptoms. An inability of the brain to maintain normal iron levels may also be involved, as iron stores in the brain of patients with RLS are reduced and iron is a cofactor in dopamine production. There is often a familial connection and a mutated gene linked to this disorder has recently been identified.
3. An urge to move the legs, usually accompanied by uncomfortable or unpleasant sensations, beginning or worsening during rest or inactivity such as lying or sitting. Symptoms are partly or totally relieved by movement such as walking, bending, stretching, etc, at least for as long as the activity continues. Symptoms only occur at night or are worse in the evening or at night than during the day.
4. Drug treatment is needed only in moderate to severe forms and mostly in elderly people. The dopamine agonists pramipexole and ropinirole are the first-line treatments; the ergot-based bromocriptine, cabergoline and pergolide are no longer favoured because of their potentially serious side effects. Anticonvulsants (gabapentin, carbamazepine or sodium valproate) are second line drugs. The shorter acting benzodiazepines alprazolam and clonazepam may also be helpful.
5. Sedating antihistamines, tricyclic antidepressants, phenothiazines, antipsychotics, MAOIs, SSRIs. Caffeine and alcohol can also intensify symptoms.

G1a, G1c, G1d, G1e, G2o, C1a.
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

Smoke alarm?

After 10 years of NHS stop smoking services, pharmacy quit rates remain low. **Jennifer Richardson** asks: what is the outlook for the sector?

How many double decker buses could a capacity crowd at Old Trafford fill? Eight hundred and seventy-five, according to a Department of Health announcement made last week to mark a decade of NHS stop smoking services.

The number of people whose lives have been saved by the initiative since 1999 could fill the Theatre of Dreams like a derby day crowd – all 70,000 of them – the DH has estimated. And with smoking cessation one of the enhanced services most often commissioned, community pharmacy should be joining in the 10th birthday celebrations.

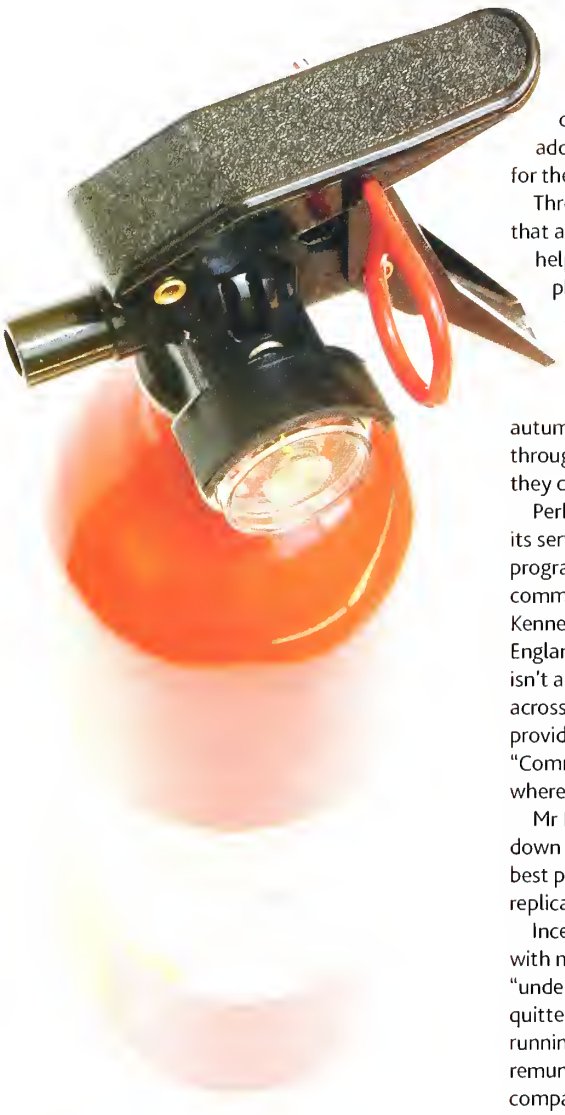
Indeed, official data shows that one in six people who stopped smoking using NHS services in England last year did so through pharmacies – that's 50,000 quitters. But the good news seems to end there. At 46 per cent, pharmacy's quit rate was the lowest of all settings considered. Hospital wards had a quit rate of 55 per cent, joint highest with military bases.

So just how big a kick in the teeth for pharmacy, and its role in the future of NHS stop smoking services, is that nine percentage point deficit? Pharmacy service experts emphasise that, first and foremost, the sector should be proud of the sheer number of people it has helped quit. They point out that many factors could have contributed to a relatively low success rate – and some may even be the very things that make community pharmacy such an ideal provider.

Some suggest that pharmacy's much-celebrated accessibility could actually contribute to its downfall in recorded quit rates. "Pharmacy is likely to be favoured... by busy smokers appreciating the easily accessible locations and opening hours," explains Alliance Boots healthcare public affairs director Tricia Kennerley. "It may be that continuity of information on such individuals is more difficult."

A snapshot from West Sussex, where a pharmacy stop smoking service was launched in January, suggests commissioners do recognise this catch 22. West Sussex PCT stop smoking manager Andy Vincent says: "Pharmacies' mixture of accessibility and informality may make access easier but it may also make follow-up visits and continuing support offered to customers more problematic."

And this is the most important thing about pharmacy's vital stats, says Numark director of professional services and training Mimi Lau: how others, namely commissioners, view and use the numbers. She says: "It is imperative pharmacists evaluate any services they provide so they can give their PCT evidence as to their own success."



Fire power: there's more to pharmacy's success in delivery smoking cesssation than just quit rates

The picture painted by statistics from Scotland is no better. There, pharmacies supported nearly half (44 per cent) of all quit attempts last year. But recent evidence suggests that just 25 per cent of smokers using pharmacy services quit after one month, compared with 48 per cent using non-pharmacy services. Community Pharmacy Scotland believes the shortfall relates to data-gathering, but it hardly appears to back last August's introduction of a national pharmacy service.

In Lothian in June, things appeared to be even worse. The local health board hoped to have 40 per cent of successful quit attempts taking place with pharmacy support – but data showed just 8 per cent were. However, NHS Lothian continued to back pharmacy's potential contribution and vowed to provide additional training and an advertising campaign for the pharmacy service.

Three months later, more recent figures show that almost half of people trying to quit with NHS help in Lothian are doing so through the pharmacy service, "clearly proving its success", NHS Lothian stop smoking co-ordinator Helen Connolly tells C+D. The board has pledged to continue the additional training throughout this autumn. Ms Connolly says: "Providing help through pharmacists gives people a place where they can come for help at a time that suits them."

Perhaps Lothian's success is also partly down to its service being part of a wider national programme – both Co-operative Pharmacy clinical commercial manager Adrian Price and Ms Kennerley bemoan the lack of consistency in England's pharmacy stop smoking services. "There isn't a standard model of contract or delivery across all PCTs which makes it confusing for both providers and patients," Ms Kennerley says. "Community pharmacy can achieve great results where the PCT is commissioning the right service."

Mr Price agrees: "The poorer PCTs will pull down the average quit rate. What we need is a best practice model for pharmacy that is replicated more frequently across the country."

Incentives are also a problem, Mr Price believes, with most pharmacy smoking cessation services "underfunded". He says: "Looking at the cost per quitter of £219/patient in the report, anybody running a pharmacy service knows that our remuneration is extremely competitive in comparison to that." Ms Lau also believes the right incentives can help boost quit rates, and highlights a Middlesbrough scheme that sees pharmacies earn a £10 bonus when a patient reaches the four-week quit target. One Numark member achieved a 72 per cent success rate in the first year under this scheme, and 69 per cent in the second.

But, statistics or no statistics, Mr Vincent remains convinced that community pharmacy is an "obvious route" for commissioners to take NHS stop smoking services into their second decade. "We recognise that community pharmacies could provide a significant contribution to the work we are doing to encourage more people to go smoke free," he says. "They have trained staff who know about the health needs of their customers and have fantastic customer service skills."

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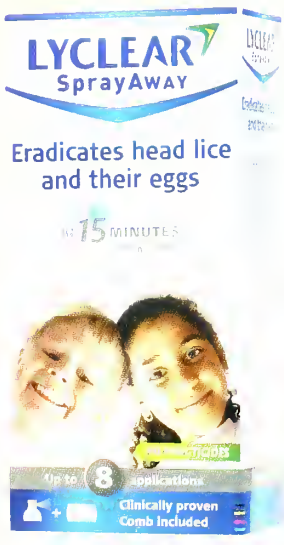

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Date of preparation: July 2009

Still unsure what the new regulations mean for you in practice? Here's C+D's cut out and keep guide to help you comply with the law

The responsible pharmacist at a glance

Responsible pharmacist? Aren't we all responsible pharmacists?

Well, yes, but from October 1 new responsible pharmacist (RP) regulations replaced the concept of personal control. They state that every pharmacy must have an RP who is legally responsible for the safe and effective running of that pharmacy.

RPs are responsible for establishing, maintaining and reviewing pharmacy procedures.

THE LAW: **if a pharmacy does not have an RP it is operating illegally.**

So might I be the responsible pharmacist?

There are no additional training requirements to be an RP. If you are the only pharmacist working in the pharmacy then you will be the RP if you accept that responsibility. If there is more than one pharmacist working you need to check with your employer who the RP is.

REMEMBER: **pharmacists with a qualification gained in another EU state may not be the RP in a pharmacy that has been open for less than three years.**

What do RPs need to know, then?

There are three main things RPs need to do to comply with the law: confirm appropriateness of SOPs on the day, update and maintain the pharmacy record, and ensure the RP sign is displayed in the pharmacy. RPs should also decide whether or not they would like to be absent from the pharmacy at any time – the new rules allow the RP of a pharmacy to be absent for up to a total of two hours on any one business day.

The NHS Terms of Service are unaffected by the new rules, so an NHS pharmacy must ensure a pharmacist is present when the pharmacy is open for the provision of NHS pharmaceutical services.

REMEMBER: **even if the RP changes during the day, only a total of two hours of absence is allowed that day.**

Sorting out the SOPs

SOPs need to be adapted to comply with the RP regulations and cover both the new requirements, such as keeping the pharmacy record, and new scenarios, such as absence of the RP.

If you need to update SOPs, you can download the NPA's templates from www.responsiblepharmacist.com.

RP action! When you become an RP you must ensure the SOPs enable the safe and effective running of the pharmacy. You should ask to see SOPs before you start work in a new pharmacy, and make amendments where necessary, either as a temporary one-off measure or as a permanent change in conjunction with the owner. You should also ensure staff understand the SOPs.

REMEMBER: **SOPs must be reviewed at least every two years or if patient safety is affected, and amendments and changes should be recorded.**

The new pharmacy record

Pharmacies must have a pharmacy record identifying who the RP is on any day and at any given time and it must be available to be viewed. The record must be professional and preserved for five years from the date of creation (if electronic) or from the date of the last entry (if on paper).

Paper versions must be stored carefully and safely, ideally bound, and electronic versions must have appropriate back-up copies and be tamper-evident.

RP action! RPs must sign in to the pharmacy record when they start work, and out when they cease being the RP. They must also record their absences.

The LAW: **failure of an RP to complete the record or of the owner to keep the record is a criminal offence.**

The new pharmacy sign

Every pharmacy must have a notice displaying who is the RP at any given time.

RP action! Before you start work you must ensure there is a sign displaying your name and registration number and that you are the RP.

RP absences

The RP regulations allow pharmacies to operate in a limited capacity without the RP present. If a second pharmacist is not available, only GSL medicines may be sold, 'bagged' prescriptions must not be handed out and P medicines may not be sold.

RP action! If you are going to be absent you must sign out on the pharmacy record. You should be contactable by staff, or another pharmacist must be available to advise them (perhaps remotely).

REMEMBER: **staff should know where absent RPs are and what to do if they don't return.**

Your daily RP checklist

- Are you happy with the SOPs? And are the procedures safe given the staffing level you have?
- Have you signed into the pharmacy record?
- Is there a pharmacy sign displaying your details?

Owners remember: you must support RPs in complying with their duties and have systems for them to raise any concerns, as well as ensuring staff know what is going on.

Locums and employees remember: as well as checking you are happy with SOPs you need to talk to employers about signing on and off as RP and whether they expect you to be absent. You may want to keep your own record of when you were or were not an RP.

More information and resources on the responsible pharmacist website

Go to www.responsiblepharmacist.com

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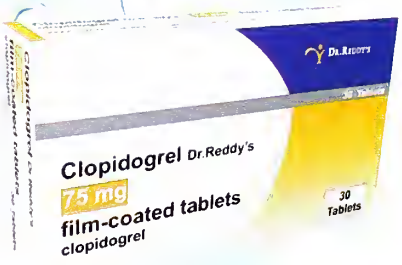

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Customers explained

There are four key types of pharmacy users you should target to improve your service offering, says **Georgina Craig**

Who's who? Turn the page to find out...

Take a look around at the customers in your pharmacy. Can you identify the Traditionalists? And can you tell the Enthusiasts from the Indulgers? If you're lucky you might spot an Avoider, though you're more likely to see them scurrying past on the high street outside. Traditionalists, Enthusiasts, Indulgers and Avoiders: government research has identified these as the four types of NHS pharmacy customers, and getting to know them could boost your business.

In 2008, the Department of Health (DH) commissioned an independent review of existing research into use of pharmacy and undertook new work to help develop its understanding of how people – especially those with long-term conditions – use the pharmacy service. And the work uncovered a whole host of statistics and insights that dispel many preconceptions and could help commissioners and pharmacies develop services more effectively.

In the past, it has been mainly larger corporate players who have had access to consumer insights data. But with the publication of this research, both local commissioners and pharmacy businesses across the board have the opportunity to take a more sophisticated approach to service development. To those who have run pharmacies, the results may seem intuitive – but to NHS managers who know little about pharmacy they may be a revelation, and broaden their minds about how the sector can help them achieve their aims.

The DH's new work segmented NHS pharmacy customers according to two main criteria:

1. The frequency of contact people already had with staff in pharmacies and how much focus individuals put on their relationship with pharmacists and other pharmacy staff.

2. The frequency with which people were already going into pharmacies and how much focus individuals put on the pharmacy environment/experience.

Four clear segments emerged:

Traditionalists: older people most often with long-term conditions (LTCs).

Enthusiasts: women aged 35 plus with caring responsibilities and busy lifestyles .

Indulgers: women looking to pamper themselves in a pharmacy with a strong beauty offering that offers a pleasant shopping environment.

Avoiders: men of all ages and ethnic groups (although men aged 55 and over are high users of pharmacy, often by proxy through a spouse).

In general, the consumers interviewed were keen on pharmacy service development. They saw the key benefits as:

- quicker/easier and more flexible access to healthcare
- less formal/structured access to healthcare (able to drop in) and therefore increased likelihood that individuals will visit on a spontaneous basis
- earlier/more frequent visits to pharmacies than other healthcare providers and therefore more focus on preventative healthcare.

People generally saw providing services through pharmacy as a sensible redistribution of workload and believed it would be good to relieve pressure on NHS services, especially pressure on GPs as that could enable them to focus on their key areas of specialism and expertise.

However, a minority were cynical and interpreted this as a way for the government to prevent them from accessing the services they wanted from GPs. Some feared it could signal a move towards charging for services delivered through pharmacies that would otherwise be free in other NHS settings.

People were also concerned about how change would be managed; they anticipated significant levels of additional investment in pharmacy training, staffing levels and skills, as well as enhanced environments being needed. People did not want to see queues and waiting times simply shift from surgeries to pharmacies.

Many people also needed help understanding and differentiating between NHS services provided by pharmacies and those offered by the pharmacy itself.

The four types of pharmacy customer

Traditionalists

Traditionalists are: often older people. Their focus is on people rather than place. They put high value on the pharmacy team and are loyal to them. But they are also heavily influenced by doctors and may feel the need to ask for their doctor's permission before using new pharmacy services.

Traditionalists want:

- MURs/support for managing long-term conditions
- stop smoking support
- treatment for minor ailments
- pharmacies in GP surgeries
- dispensing services

Enthusiasts

Enthusiasts are: most often women aged 35 plus with a family or other caring responsibilities. They may have a chronic condition themselves or be caring for a child with a long-term illness. They use a wide range of pharmacies for convenience because they have busy lifestyles, but prefer a pharmacy that combines a pleasant retail environment with services and the chance to seek advice.

Enthusiasts want:

- advice on keeping well
- NHS health checks
- adult screening for high blood pressure and diabetes
- treatment for minor ailments
- dispensing services

Indulgers

Indulgers are: younger women, both those with and without long-term conditions. They go to pharmacy mainly for the retail experience and may feel embarrassed talking to the pharmacist. They favour pharmacies with a large beauty offering and pleasant retail environment.

Indulgers want:

- dispensing services
- supply of contraception
- healthy lifestyle advice with a particular emphasis on diet
- treatment for minor ailments
- chlamydia testing and treatment

Avoiders

Avoiders are: typically male. They include teenagers, Afro-Caribbean men and older men who often rely on others to go to the pharmacy on their behalf. While they tend to actively avoid going, they sometimes express a preference for the anonymity of supermarket pharmacies.

Avoiders want:

- treatment for minor ailments
- sexual health services (teenage men) – contraception, advice on sexually transmitted diseases, chlamydia testing and treatment
- healthy living advice on optimising health and fitness (men aged 18 to 24)
- NHS health checks combined with advice on keeping well; screening for high blood pressure and diabetes (men aged 25 to 55)

For a full copy of the DH's consumer research visit http://tinyurl.com/3ctx8b

A key finding related to people with LTCs. Their view was influenced more by their demographic characteristics, most notably age and gender, than by their diagnosis. This has implications for how pharmacies and commissioners communicate with them. And, as they tend to use pharmacies more than others within their segment, they are worthy of special attention. They express particular interest in medicines use reviews (MURs) and ongoing pharmacy support and care. The DH researchers commented: "People with asthma have told us in focus groups that they like to be able to talk to pharmacists about their asthma medicines.

"They have also mentioned pharmacies as being easy to access (including out-of-hours), meaning that their accessibility is an important part of their role. However, only 15 per cent of people with asthma tell us they have received asthma advice from a pharmacist in the past year... there is relatively low awareness of the availability of medicines use reviews among people with asthma from ethnic minority backgrounds."

Pharmacy has always understood the need to focus on the needs of its retail customers. Applying the same principle to its NHS customers is a small leap of faith – but an essential step for those set on a future centred on clinical service delivery. Making the most of these DH insights will be a key part of that process.

Georgina Craig is an independent healthcare consultant and former CCA commissioning lead

How to use this research

In-house

Reflect on your own customer base. Think about the services you offer and how you market them. Refocus your marketing and communications using insights from the research to make your messages more attuned to your customers' needs.

With local commissioners

- Work with your PCT to think about how this research can be used to underpin pharmacy service development. For instance, if local pharmacists are focusing on MURs for long-term conditions, this research suggests that GP referral and endorsement would encourage traditionalists to use the service. Gaining GP support would ensure maximum impact of MURs among this key target group for the service.
- Encourage your PCT to use this research as part of its pharmaceutical services commissioning process to inform everything from developing its pharmaceutical needs assessment through to service redesign.
- Encourage your PCT's pharmaceutical services commissioning leads to share these insights with primary care commissioning colleagues, so they understand pharmacy's user base and how pharmacy services can reach groups they want to target through primary and community services commissioning.

onwards with alli

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The recent Coventry Community Pharmacy Weight Management Project underlined that customers are eager for the "friendly", accessible support of Pharmacy.[3] Even those not actively considering weight loss may be interested to know that a skilled professional is available for one-to-one advice on lifestyle change. MURs are an ideal opportunity for a conversation about weight loss and, where appropriate, clinically proven **alli**. Leaflets and posters create awareness, as can simple questions like: "Are you interested in ways that could help you do better on your diet?"

> *"By being proactive, pharmacies can engage customers further with this proven weight loss aid"*
> Dr Terry Maguire, Fellow of the Royal Pharmaceutical Society of Northern Ireland

Pharmacy managers will strike their own balance between expanding services and business as usual. Are you satisfied enquiring into your customers' progress and giving tips on diet and exercise? Do you have the resources available to establish a full scale intervention with regular consultations and goal setting, weight-loss clinic reviews?

Either on a commissioned basis or by signposting to local services, pharmacy weight loss management can underpin the fundamental importance of diet and exercise. In suitable individuals, **alli** could also be offered as a helpful adjunct to a structured weight loss effort.

The availability of **alli** is a chance for Pharmacy to widen the weight loss conversation – added value that can help pharmacies capture a competitive advantage and strengthen customer loyalty. By visiting mypharmassist.couk, you can find out more about managing weight loss with the **alli** training materials.

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Confessions of a tax offender

If you might have missed something in your tax return, you can now use the Inland Revenue's 'New Disclosure Opportunity' to declare it, says tax expert **Rebecca Busfield**

In the hustle and bustle of running a pharmacy, it can be easy to make a mistake despite the best of intentions. But, for once, we're not talking about dispensing errors. In compiling your tax return it's quite possible to have forgotten to declare an asset you have bought or sold; to have thought that you didn't have to declare the staff Christmas drinks each year; or to have miscalculated the dividends you have received.

Whichever way, you might have put it to the back of your mind, thinking that the taxman would not be interested in small details anymore.

Unfortunately, he always will be – and now might be a good time to check for discrepancies and set the record straight by disclosing anything you have missed. Why? Because HM Revenue & Customs (HMRC) is running a tax amnesty, called the New Disclosure Opportunity (NDO).

What is the NDO?

HMRC has introduced the NDO to encourage individuals and companies with unpaid taxes to declare in exchange for a smaller than usual penalty.

It allows those with unpaid taxes linked to overseas bank accounts, investments, businesses or assets to settle their tax liabilities at a favourable penalty rate of 10 per cent. And HMRC has said that unprompted domestic disclosures made during the NDO period, where there is no offshore account, may attract the same reduced penalty.

How do I use the NDO?

To use the NDO, a notification of the intention to disclose must be made to HMRC by November 30. The disclosure must then be made by March 12, 2010.

The NDO can be submitted online using a standard form. This is a huge advantage for serious cases where a detailed disclosure report would otherwise be expected. HMRC is less likely to ask in-depth questions and the professional fees for assisting are substantially less in comparison with a normal enquiry.

Taxpayers have only one chance to make a disclosure so it is important to make sure it is accurate. Any agreement with HMRC will be cancelled if the actual facts differ from those disclosed. In serious cases HMRC may decide to prosecute if materially false statements are provided.

HMRC will also reduce the penalty based on the quality of the disclosure, such as giving HMRC assistance in quantifying the unpaid tax, explaining how and why the unpaid tax arose, attending meetings with HMRC, volunteering information and allowing access to records.

What if I don't use the NDO?

Those who choose not to use the NDO and are subsequently found to have undeclared tax liabilities are likely to face a penalty of between 30 per cent and 100 per cent of the tax unpaid and an increased risk of criminal prosecution.

Why should I disclose unpaid taxes?

In order to encourage disclosure, HMRC has set the maximum and minimum penalty levels 50 per cent lower where an "unprompted" disclosure is made. This means at a time when the person or company making the disclosure has no reason to believe that HMRC has discovered or is about to discover the inaccuracy or underassessment, and can have a substantial effect on the amount of the overall settlement package.

What if I don't disclose?

Where unpaid tax is discovered by HMRC, taxpayers are required to pay back the tax and late payment interest. HMRC can be flexible with payment timing but will demand that the whole amount is eventually repaid; some have been forced to sell their houses and, in exceptional cases, forced into bankruptcy.

Taxpayers who are found to have deliberately evaded tax and concealed their actions can expect a penalty of between 50 per cent and 100 per cent of the tax unpaid. Where fraud has been committed, HMRC may collect tax from up to 20 years ago.

HMRC will usually open an enquiry into your tax affairs and for very serious cases will expect a full disclosure report to be prepared. HMRC recommends that taxpayers use specialist, professional tax advisers to help to manage an enquiry or prepare a full disclosure report, and the costs can be significant – although often result in substantial tax savings and reduced penalties.

It can take up to 18 months for the necessary facts to be collated and analysed as part of an enquiry, which can include bank statements, legal documents, personal details and inventories of assets and liabilities. In serious cases holidays can become difficult and day-to-day family and business life is disrupted.

From 2010, HMRC will 'name and shame' evaders who have underpaid more than £25,000 tax. Even those who have underpaid as little as £5,000 will be given a 'tax ASBO' and will be intensively monitored by HMRC.

For more information about the NDO, visit www.hmrc.gov.uk/offshoreaccounts/offshore-ndo.htm

Rebecca Busfield is a senior associate in the tax disputes and investigations department of Alvarez and Marsal Taxand UK LLP

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Leader of the pack

Cluster lead manager Payal Vasani finds responsibility for six Lloydspharmacy branches the perfect stepping stone into multi-store management

Payal Vasani has worked her way steadily up the Lloydspharmacy hierarchy since joining the company as a pre-registration trainee in 2002.

Following the well-trodden path of a typical multiple pharmacy career pathway, she started her fully-qualified days as a relief pharmacist and was quickly promoted to branch manager, then flagship pharmacy manager.

But then, some half a decade on from her first working day in the profession, Ms Vasani's most obvious next career move was more of a leap than a step up.

Lloydspharmacy recognised that the traditional move from a branch manager role – even in a flagship or area lead store – to an area manager position that comes with responsibility for tens of stores could be "a big jump", says head of capability Barbara Sutherland.

So the multiple has introduced a new role to its business model, a new level in the hierarchy to bridge the gap. Cluster lead managers (CLMs) hold responsibility for between four and eight branches, reporting to the area manager.

They were introduced last year by internal staff movement and promotion, but Lloydspharmacy is now rolling the positions out for external applications.

Ms Vasani has taken the CLM role for Hemel Hempstead and is accountable for six stores' performances against the company's key targets and for developing their branch managers.

She spends four days a week as a branch manager herself, and the two afternoons she spends in her cluster lead role she will usually be visiting the other stores in her cluster.

"I go in there and make sure all simple operational targets are being met, such as health and safety, SOPs, stock management, and are the team well presented?" she says. "Other days I look at my budgets and targets and how each pharmacy is doing and if there is anything I can do to help."

Every Monday morning, Ms Vasani and all the other CLMs in her area have a conference call with area manager Ingrid Crookshank to discuss their focus for the week and share ideas.

Ms Vasani also meets up with Ms Crookshank approximately once a month to set out the upcoming challenges. This afternoon she is heading off to help mentor a new dispenser, and is fully enjoying her new position. "The great thing about the cluster lead manager role is that it's made me more business focused," she says. "It's given me a chance to grow within the company."

There are no specific qualifications or experience levels needed for the CLM role – it is open to both pharmacists and non-pharmacist branch managers and Ms Sutherland says one CLM was appointed after just two years' pharmacy experience. "It's down to the capability of the individual," she explains.

One thing that is clear, though, is the underlying qualities prospective CLMs need; Ms Vasani, Ms Crookshank and Ms Sutherland all agree that the most important thing is people skills. As a CLM, you need to manage people who you are not in daily face-to-face contact with.

So, says Ms Sutherland: "They have got to be someone who can inspire and motivate people." She adds: "You have got to be able to communicate effectively through various means."

Ms Crookshank suggests that a CLM would also need to be "somebody who's a bit of a go-getter, wanting to progress and do different things". She says: "They need to be ready to get out of their comfort zone." And Ms Sutherland agrees: "We'd be looking for someone with high standards for themselves who would lead by example."

The key challenge for CLMs, says Ms Vasani, is time management – an area in which her skills are "definitely improving". She says: "If you prioritise it can be managed well." She concludes: "It's a fantastic challenge and a fantastic role. It helps you develop your skills – you can be a pharmacist but also think outside the box and think commercially."

A cluster manager role has made Payal Vasani "more business focused"

What is a cluster lead manager?

- Responsible for the performance of four to eight pharmacies (a cluster)
- Reports to the area manager
- Four days a week as a branch manager
- One day a week visiting other stores in cluster
- Line manager responsibilities for the branch managers of those pharmacies.

Tempted? Lloydspharmacy has created around 300 CLM positions across the country – and around 40 of these are vacancies, mainly in the South West and Midlands. Those taking on the role will be given business and people skills training as well as being assessed for additional individual training needs.

You will need: people and communication skills; good time management.

Apply if: you want a stepping stone to management

Only if you don't mind: leading by example.

For more information or to apply for a cluster lead manager role, visit **www.chemistanddruggistjobs.co.uk/job/2890/cluster-lead-managers**

The area manager perspective

The introduction of cluster lead managers (CLMs) has made working life more pleasant for Lloydspharmacy's area managers, says Ingrid Crookshank.

"It's really difficult to be the line manager for as many people as we have been in the past," says Ms Crookshank, who now has six CLMs reporting into her. "It's quite nice working with a team of people who you are sharing a lot of responsibility with."

Previously, says Lloydspharmacy head of capability Barbara Sutherland, area managers were spending too much time "fire fighting", and not enough on longer term objectives such as building relationships with local communities, commissioning and tendering.

And Ms Crookshank agrees the CLM role has alleviated this problem. She says: "It's freeing up a lot of time to do the things that are really important for building the business."

Chief Executive

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The PCC represent the interests of community pharmacy contractors in Northern Ireland and due to the retirement of the incumbent, now wishes to appoint a new Chief Executive. The successful candidate will be responsible for the overall performance of the organisation, ensuring that it delivers the key strategic and operational objectives agreed by the Board. Based in Belfast and reporting to the Board, the appointee will be required to provide effective management and leadership through a period of comprehensive modernisation.

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For further information on the essential criteria and to apply for an application form and information pack please contact, quoting ref PCC/09, Karen Begg, PricewaterhouseCoopers LLP, Waterfront Plaza, 8 Laganbank Road, Belfast BT1 3LR. Telephone **028 9041 5701**. Email **pwcni.recruitment@uk.pwc.com** or you can download the same information and an application form from **www.nijobs.com**

Application forms and information packs can be made available in accessible formats upon request.

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

Dealing with dragons

A close shave with a dragon to report this week – fortunately us Welshmen are not scared of these mythical beasts! What am I talking about? Well, it all started a few weeks ago when I heard about a mysterious visitor on my day off.

"He did what to the locum?" I asked.

"He mummified him!"

Thinking that somebody was trying to confuse me I thought it was best not to enquire any further. And a few days later all of my questions were answered when the mysterious visitor returned brandishing something he wanted to show me...

This is going to be good, I thought, as I led him to my consultation room. "Roll your sleeve up," he commanded, and I nervously did as requested.

Out of his bag came a packet, and out of the packet came a bandage. Relief washed over me like a wave: a revolutionary new type of rechargeable cold compression bandage! The results were pretty impressive as I felt my arm first go cold, then go numb. I thanked my visitor for the demonstration and said that we may be willing to stock his product (they only lived in the next village).

Then a few weeks later, while watching Dragon's Den on TV, I saw the product being demonstrated on one of the Dragons. Since we had bought a starter pack of the bandage it was great to see it, but now I realise that we have inadvertently gone into business with Deborah Meaden!

> ROLL YOUR SLEEVE UP, HE COMMANDED, AND I NERVOUSLY DID AS REQUESTED

What a star!

A pharmacy student is putting his skills to good use by heading out to Goa to screen patients for diabetes.

Shailen Karia (pictured above), who has just finished his second year at De Montfort University, has darted out to India's smallest state to spend two weeks screening for the chronic condition.

The screening initiative is run by charity the Silver Star Appeal, which operates mobile assessment units that offer free diabetes tests for the local community. Patrons for the charity include glamorous star and Celebrity Big Brother winner Shilpa Shetty, and Bollywood legend Amitabh Bachchan.

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

A pharmacist turned crime-busting detective in C+D's August 1860 issue, when he cracked the case of the Wrangle cholera victim.

Pharmacist Mr Cherrington grew suspicious when a Mr Dodd of Wrangle, Lincolnshire, fell ill with "purging and vomiting". The local doctor decided Mr Dodd had cholera, and nobody was surprised when Mr Dodd died the next day of "bilious diarrhoea"; nobody, that is, except Mr Cherrington.

The inquisitive pharmacist remembered that shortly before the alleged cholera attack, Mr Dodd's wife had bought a quarter of a pound of arsenic. Asking about the town, Mr Cherrington found the couple "had not lived on very comfortable terms" and Mrs Dodd had often threatened her husband.

Suspecting foul play, Mr Cherrington called the police to demand Mr Dodd's body was exhumed. The post mortem revealed arsenic as the cause of death, and Mrs Dodd was sent down for the "wilful murder" of her hubby.

Lloydspharmacy goes sky blue

Postscript is a little surprised to hear about the latest signing of football Championship side Coventry City – Lloydspharmacy.

The sky blues have made the Coventry-based multiple their official healthcare partner for 2009-10, and main sponsor of the club's Good Sports school scheme.

The scheme involves a football-themed game board for teachers to record how much time kids spend on physical activities. The most active classes will be rewarded by a visit from a Coventry City player.

Lloydspharmacy also plans health events for grown-ups at Coventry's home ground, the Ricoh Arena, and will sponsor two of City's home matches this season.

Postscript hopes the partnership is successful as City strives to return to the Premiership, but can't help but wonder who is sponsoring City's boots.

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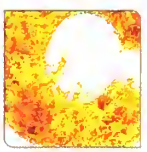

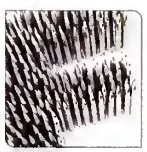
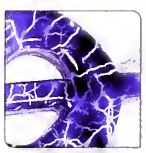
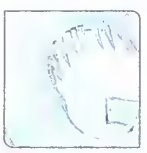

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